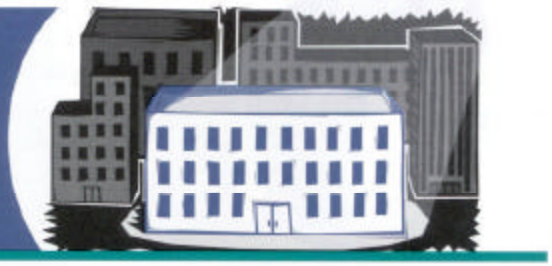
Spotlight on Success



An Interdisciplinary Process for Medical Record Review

Vital Statistics

Facility Facts

Eleanor Slater Hospital (ESH), a 628-bed public hospital spanning two campuses in Cranston, Rhode Island, is operated by the State of Rhode Island's Department of Mental Health, Retardation and Hospitals. The facility treats patients with acute and long term medical illnesses as well as psychiatric disorders. Most patients are admitted from community hospitals or other health care facilities and require hospital-level long term care.

Purpose of the Project

In fall 2001 ESH began a performance improvement (PI) project to address its medical record review process and ultimately improve medical record documentation.

Outcomes

Before the project, ESH knew its staff members were doing good work with patients, but this work was not being reflected in the documentation. After the PI project was put in place, documentation increased and medical records began being completed appropriately, showing the variety of interventions being done at the facility.

Eleanor Slater Hospital (ESH) is not your typical hospital. "We usually categorize ourselves as a long term, acute care facility," says Edward Martin, M.D., Chief of Medical Staff and Clinical Services. "Most of the time, patients are referred to us from other health care facilities because they require an ongoing intensity of service that can be found only in a hospital like ours." ESH provides psychiatric, long term, and acute care services. Many patients have complex behavioral and psychiatric issues in addition to their medical problems. Often an individual will pass through each type of care in the facility and receive several interventions along the way.

All these factors contribute to the organization's need to have complete and thorough medical records. In fall 2001 ESH embarked on a PI project to address the organization's review of medical records and improve the quality of medical record documentation.

A Perspective Shift

The PI process was started for a variety of reasons. The organization was experiencing an ideology shift. Leadership was recognizing that while the facility operated well, it could improve in certain areas. In looking at the medical records, the organization realized that although staff was providing quality care, it often wasn't reflected in the records. The organization was confident in its policies and their implementation by staff, but discovered a disconnect in getting implementation documentation into the medical records.

During this time, ESH was also moving from a triple medical record—which included psychiatric, long term care, and acute care services records—to a single record format. As a patient moved through the different areas, a new chart was used in each area. "In some cases, depending on the patient, he or she could have many different medical records. This was a problem for ensuring the continuity of care," Martin explains. So the hospital switched to a single medical record that each division would have access to. ESH started the medical record review PI project as a way to troubleshoot the new system.

The Joint Commission requires all hospitals to periodically review a representative sample of their medical records for completeness, timeliness, and legibility of information. From this, organizations are expected to take any actions necessary to improve quality and timeliness. ESH targeted its PI project to directly address these requirements.

Developing the Process

The PI process was developed by ESH's Medical Records Standards Compliance Committee. This group, co-chaired by Manish B. Desai, M.D., and Ouilda Masi, A.R.T., is composed of representatives from each department that enters information on the medical record. Members include staff from the dietary, therapeutic recreation, social work, psychology, rehabilitation services, administration, and performance improvement departments, as well as nurses and physicians. "Basically, our philosophy is: If your department is writing in the medical record, you should have a representative on the committee," Martin says.

The project itself involves looking at a random sample of 40 active medical records each quarter. ESH chose to review active medical records because it allowed for a dynamic process that could provide direct feedback to staff. Each department reviews its section of the selected medical records. The review is based on the standards that are required to be met for each department, as well as other indicators. ESH adapted a form from JCAHO's Web site that lists the required documentation for the medical record (see the sidebar). Each department uses this form as a checklist to indicate the presence or

absence of required information.

The committee reviews the findings from each department at its quarterly meeting and identifies areas that need attention. Suggestions such as new procedures or staff education and training are developed by this group as well as by the appropriate department. For example, during one quarter the committee discovered that although the dietary department was documenting changes in patients' weight, it did not adequately document any interventions or explanations that addressed these changes. The dietary department was providing such interventions and explanations but was not documenting them. The dietary department trained its dieticians on appropriate documentation, and subsequently the medical records improved.

Each quarter, a new random sample of 40 records is chosen for review. In some cases, the same records are seen more than once, but, Martin says, "A lot of times when a patient is being treated over a long period of time, information can drop off the medical record. This review process prevents that from happening."

Measuring Effectiveness

To measure the effectiveness of this project, ESH looked at several indicators, including

- a complete assessment;
- documented care;
- signed and legible notes; and
- standards met.

Before the PI project began, compliance with these indicators was about 60% to 70%. The organization was targeting 95% compliance. Since implementation, ESH has seen an improvement in compliance with these indicators. Interventions are now more accurately documented, offering a clearer picture of a patient's treatment.

One reason for the success of this project was the management support. "In the past, staff members were concerned they would be ostracized if they pointed out deficiencies in the medical record. With this effort, the tone was set early by management that people would not be punished if there were serious deficiencies in documentation," Martin explains. ESH focused its efforts on getting any issues on the table to address them rather than punishing individuals for inadequate documentation.

According to Martin, another reason for the program's success is its interdisciplinary nature. "I don't think the project would have been successful if it were just a medical record clerk reviewing the records and noting problems. It's better to have the departments involved in reviewing themselves so they can determine the best approach to improving documentation and providing education." As the project progressed, staff in all the affected departments became more aware of the medical record and the documentation required. Staff are responsive to the project because they realize the best way to receive recognition for work done is to document it.

Looking to the Future

ESH would like to add more departments to the medical record review process. For example, the organization has identified a need to document the spiritual care that patients receive. Because of the nature of the patient population, spiritual care is important to the overall patient treatment. ESH has a number of chaplains and, in the past, their work has not been documented in the medical record. ESH is looking to bring this group of professionals into the process to begin documenting the spiritual work they do with patients. In addition, the organization would like a representative from this group to have a place on the committee and participate in the review process.

Medical Records Monitoring Tool

Eleanor Slater Hospital adapted a form on JCAHO's Web site as part of its PI project on medical record review. The dietary section is only one part of a longer form that ESH uses in its medical record review process. To access the JCAHO forms, go to *www.jcaho.org*, select "Hospitals," click on "Survey Process" from the menu on the left, click on "Sample Forms and Tools," and select "Hospital Surveyor Medical Record Review Tool." Behavioral Health Care, Home Care, and Long Term Care have similar forms in their Survey Process sections.

DIETARY

A = Absent; NA = Not applicable; PC = Present and complete; PI = Present but incomplete

	Areas of Review	CAMH Standard	Record #	Record #	Record #	Record #	Record #	Record #	Record #	Record #	Record #
1	A nutritional screen within 24 hours	PE.1.2									
2	Nutritional assessment of nutritional status	PE.1.2									
3	Reassessment includes progress notes	PE.2.2									
4	Reassessment includes periodic assessment	PE.2.2									
5	Reassessment includes a patient's response to care	PE.2.2									
6	A significant change in the patient's condition results in reassessment	PE.2.3									
7	Were care decisions based on the identified patient needs and care priorities?	PE.3.1									
8	The patient is educated about nutrition interventions, modified diets, or oral health, when applicable	PF.3.2									